		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036152

Facility Name: Rosewood Care Center of Moline

Address: 7300 Thirty Fourth Avenue (Number) Moline (City) 61265 (Zip Code)

County: Rock Island

Telephone Number: (309) 792-5940 **Fax #** ( )

IDPA ID Number: 431453169001

Date of Initial License for Current Owners: 5/6/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2001 to 6/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) Accountant's Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			11,049	11,049	8
9	SNF/PED					9
10	ICF	3,286	18,305		21,591	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,286	18,305	11,049	32,640	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.52%

D. How many bed-hold days during this year were paid by Public Aid?
4 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/7/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/7/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 11,049

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2002 Fiscal Year: 6/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	178,315	19,050	6,859	204,224		204,224		204,224			1
2	Food Purchase		156,893		156,893		156,893	(9,162)	147,731			2
3	Housekeeping	119,544	22,040		141,584		141,584		141,584			3
4	Laundry	38,889	22,270		61,159		61,159		61,159			4
5	Heat and Other Utilities			97,459	97,459		97,459	424	97,883			5
6	Maintenance	21,407	6,088	80,053	107,548		107,548	18,033	125,581			6
7	Other (specify):* Sanitation			18,321	18,321		18,321		18,321			7
8	**TOTAL General Services**	358,155	226,341	202,692	787,188		787,188	9,295	796,483			8
	B. Health Care and Programs											
9	Medical Director			25,363	25,363		25,363		25,363			9
10	Nursing and Medical Records	1,806,784	179,121	50,955	2,036,860		2,036,860		2,036,860			10
10a	Therapy	56,858	1,330	685,406	743,594		743,594	(203,941)	539,653			10a
11	Activities	41,321	1,666	1,960	44,947		44,947		44,947			11
12	Social Services	32,883		1,960	34,843		34,843		34,843			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,937,846	182,117	765,644	2,885,607		2,885,607	(203,941)	2,681,666			16
	C. General Administration											
17	Administrative			870,877	870,877		870,877	(716,805)	154,072			17
18	Directors Fees											18
19	Professional Services			8,227	8,227		8,227	37,435	45,662			19
20	Dues, Fees, Subscriptions & Promotions			25,335	25,335		25,335	(6,803)	18,532			20
21	Clerical & General Office Expenses	142,172	41,991	15,139	199,302		199,302	164,383	363,685			21
22	Employee Benefits & Payroll Taxes			262,980	262,980		262,980	32,191	295,171			22
23	Inservice Training & Education											23
24	Travel and Seminar			958	958		958	(23)	935			24
25	Other Admin. Staff Transportation			7,137	7,137		7,137	18,466	25,603			25
26	Insurance-Prop.Liab.Malpractice			35,775	35,775		35,775	6,579	42,354			26
27	Other (specify):*											27
28	**TOTAL General Administration**	142,172	41,991	1,226,428	1,410,591		1,410,591	(464,577)	946,014			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,438,173	450,449	2,194,764	5,083,386		5,083,386	(659,223)	4,424,163			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center of Moline #0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation					16,824	16,824	122,977	139,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,519	66,519		66,519	799,110	865,629			32
33	Real Estate Taxes			93,737	93,737		93,737		93,737			33
34	Rent-Facility & Grounds			1,406,384	1,406,384		1,406,384	(1,393,022)	13,362			34
35	Rent-Equipment & Vehicles			11,884	11,884		11,884		11,884			35
36	Other (specify):*			16,824	16,824	(16,824)						36
37	**TOTAL Ownership**			1,595,348	1,595,348		1,595,348	(470,935)	1,124,413			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,773	20,259	240,032		240,032	(2,082)	237,950			39
40	Barber and Beauty Shops			2,258	2,258		2,258		2,258			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		219,773	88,217	307,990		307,990	(2,082)	305,908			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,438,173	670,222	3,878,329	6,986,724		6,986,724	(1,132,240)	5,854,484			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,726)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,698)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,082)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(436)	2		13
14	Non-Care Related Interest	(66,519)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(23)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(669)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,746)	20		28
29	Other-Attach Schedule Marketing Salary	(60,524)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,423)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(972,817)	Var	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (972,817)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,132,240)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rosewood Care Center of Moline

ID# 0036152

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (60,524)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(60,524)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Moline **#** 0036152 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,162)	0	0	0	0	0	0	0	0	0	0	(9,162)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	424	0	0	0	0	0	0	0	0	424	5
6	Maintenance	0	0	18,033	0	0	0	0	0	0	0	0	18,033	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,162)	0	18,457	0	0	0	0	0	0	0	0	9,295	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(203,941)	0	0	0	0	0	0	0	0	0	(203,941)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(203,941)	0	0	0	0	0	0	0	0	0	(203,941)	16
	C. General Administration													
17	Administrative	0	(870,877)	154,072	0	0	0	0	0	0	0	0	(716,805)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	37,435	0	0	0	0	0	0	0	0	37,435	19
20	Fees, Subscriptions & Promotions	(7,415)	0	612	0	0	0	0	0	0	0	0	(6,803)	20
21	Clerical & General Office Expenses	(60,524)	0	224,907	0	0	0	0	0	0	0	0	164,383	21
22	Employee Benefits & Payroll Taxes	0	0	32,191	0	0	0	0	0	0	0	0	32,191	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(23)	0	0	0	0	0	0	0	0	0	0	(23)	24
25	Other Admin. Staff Transportation	0	0	18,466	0	0	0	0	0	0	0	0	18,466	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,579	0	0	0	0	0	0	0	0	6,579	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(67,962)	(870,877)	474,262	0	0	0	0	0	0	0	0	(464,577)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,124)	(1,074,818)	492,719	0	0	0	0	0	0	0	0	(659,223)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	99,068	23,909	0	0	0	0	0	0	0	0	122,977	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(80,217)	879,327	0	0	0	0	0	0	0	0	0	799,110	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,406,384)	13,362	0	0	0	0	0	0	0	0	(1,393,022)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(80,217)	(427,989)	37,271	0	0	0	0	0	0	0	0	(470,935)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,082)	0	0	0	0	0	0	0	0	0	0	(2,082)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(2,082)	0	0	0	0	0	0	0	0	0	0	(2,082)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,423)	(1,502,807)	529,990	0	0	0	0	0	0	0	0	(1,132,240)	45

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 870,877	HSM Management	100.00%	$	$ (870,877)	1
2	V								2
3	V	10a	Therapy	685,406	Rosewood Therapy Company, Inc.	0.00%	481,465	(203,941)	3
4	V								4
5	V	34	Rent	1,406,384	Moline Real Estate, Inc.	0.00%		(1,406,384)	5
6	V	30	Depreciation		Moline Real Estate, Inc.		99,068	99,068	6
7	V	32	Interest		Moline Real Estate, Inc.		864,012	864,012	7
8	V	32	Amortization - Loan Fee		Moline Real Estate, Inc.		15,315	15,315	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,962,667			$ 1,459,860	$ * (1,502,807)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 154,072	$ 154,072	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	224,907	224,907	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	32,191	32,191	17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	18,466	18,466	18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	23,909	23,909	19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	13,362	13,362	20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	37,435	37,435	21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	6,579	6,579	22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	18,033	18,033	23
24	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	424	424	24
25	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	612	612	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 529,990	$ * 529,990	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	820,412	3	6.41%	Salary	$ 56,168	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	584,717	3	6.41%	Salary	40,031	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,199		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	78,691,907	17	$ 1,501,328	$ 1,501,328	5,042,268	$ 96,199	1
2	21	Salaries - Others	Total Cost	78,691,907	17	2,971,209	2,971,209	5,042,268	190,383	2
3	22	Payroll Taxes	Total Cost	78,691,907	17	275,345		5,042,268	17,643	3
4	22	Employee Benefits	Total Cost	78,691,907	17	147,178		5,042,268	9,431	4
5	25	Travel	Total Cost	78,691,907	17	280,565		5,042,268	17,978	5
6	30	Depreciation	Total Cost	78,691,907	17	359,545		5,042,268	23,038	6
7	34	Building Rent	Total Cost	78,691,907	17	208,527		5,042,268	13,362	7
8	19	Professional Services	Total Cost	78,691,907	17	584,225		5,042,268	37,435	8
9	21	Telephone	Total Cost	78,691,907	17	234,306		5,042,268	15,013	9
10	26	Insurance	Total Cost	78,691,907	17	102,679		5,042,268	6,579	10
11	21	Taxes, Licenses & Other Sup.	Total Cost	78,691,907	17	304,491		5,042,268	19,511	11
12	6	Maintenance	Total Cost	78,691,907	17	276,408		5,042,268	17,711	12
13	5	Heat & Other Utilities	Total Cost	78,691,907	17	6,619		5,042,268	424	13
14	20	Dues & Subscriptions	Total Cost	78,691,907	17	9,548		5,042,268	612	14
15	17	Direct - Admin	Direct Cost	1	1	57,873	57,873	1	57,873	15
16	17	Direct - Admin	Direct Cost	16	16	930,846	930,846	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	5,117		1	5,117	17
18	22	Direct - Payroll Taxes	Direct Cost	16	16	73,899		0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	871		1	871	19
20	30	Direct - Depreciation	Direct Cost	16	16	15,438		0	0	20
21	25	Direct - Travel	Direct Cost	1	1	488		1	488	21
22	25	Direct - Travel	Direct Cost	16	16	15,339		0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	322		1	322	23
24	6	Direct - Maintenance	Direct Cost	16	16	2,904		0	0	24
25	TOTALS					$ 8,365,070	$ 5,461,256		$ 529,990	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage Refinancing	$85,767.00	10/26/99	$ 10,312,500	$ 10,024,131	11/2009	8.89%	$ 906,201	1
2	Amortization of Loan Fees										15,315	2
3	Less: Related Party Interest										(42,189)	3
4	Interest Income										(13,698)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$85,767.00		$ 10,312,500	$ 10,024,131			$ 865,629	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,312,500	$ 10,024,131			$ 865,629	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	116,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	92,222	2
3. Under or (over) accrual (line 2 minus line 1).	$	(23,978)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	117,715	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	93,737	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	85,527	8
	1998	84,641	9
	1999	89,050	10
	2000	91,822	11
	2001	93,421	12

2000 Payment -$68,867

2001 Payment - $23,355

Accrual = Balance of 2001 (70,065) +1/2 of Estimated 2002 (47,650)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0036152

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-649-95-00	Lot 2 Rosewood 1st Add	$ 93,420.56	$ 93,420.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,420.56	$ 93,420.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	4.4 Acres	1989	$ 210,330	1
2					2
3	TOTALS	#VALUE!		$ 210,330	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1990	$ 2,845,310	$	40	$ 71,133	$ 71,133	$ 865,451	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Improvements			1990	277,100		20-25	11,097	11,097	135,012	9
10	Curbing			1991	2,743		25	110	110	1,210	10
11	Landscaping			1991	4,560		25	182	182	1,987	11
12	Irrigation System			1993	10,257		25	410	410	3,656	12
13	Water Meter & Back			1993	1,803		25	72	72	636	13
14	Walk-in Cooler			1990	7,845		20	392	392	4,769	14
15	Sinks			1990	6,386		10	62	62	5,906	15
16	Exhaust Hood w/Fire Extinguisher			1990	6,317		10			6,317	16
17	Generator			1990	15,779		20	789	789	9,599	17
18	Signage			1990	2,721		15	182	182	2,214	18
19	Facility Signs			1990	1,757		10			1,757	19
20	Cubicle Curtain Track			1990	6,176		10			6,176	20
21	Fire Alarm System			1990	99,726		10			99,726	21
22	Hot Water Heater			1990	6,706		10			6,706	22
23	Water Heater Tank			1990	7,961		10			7,961	23
24	Wallcovering			1990	24,650		10			24,650	24
25	Carpeting			1990	8,025		10			8,025	25
26	Steel Trash Doors			1991	1,825		10	56	56	1,825	26
27	Parking Lot Addition			2000	11,485		25	459	459	765	27
28											28
29	Leasehold Improvements - Facility:										29
30	Painting/Floor Stripping			1995	9,426	837	7	837		9,426	30
31	Carpeting			1995	292	42	7	42		280	31
32	Carpeting			1996	14,000	2,000	7	2,000		12,833	32
33	Cabinet Work			1996	1,868	267	7	267		1,713	33
34	Base Stripping			1996	1,509	216	7	216		1,361	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting	1996	$ 19,996	$ 2,857	7	$ 2,857	$	$ 16,471	37
38	Wallcoverings/Bathrooms Mirrors/Plants	1999	11,651	1,664	7	1,664		5,525	38
39	Drapery/Office Space/Counter	1999	2,256	323	7	323		1,190	39
40	Wallcoverings/Bathrooms Mirrors/Plants	1999	15,783	2,255	7	2,255		6,339	40
41	Carpeting	2000	4,718	674	7	674		1,455	41
42	Flooring	2000	2,371	339	7	339		537	42
43	Countertops	2000	3,894	556	7	556		880	43
44	Paneling	2000	1,270	181	7	181		287	44
45	Room Signs	2000	1,082	155	7	155		245	45
46	Sink	2000	1,935	276	7	276		437	46
47	Computer Cabling	2000	2,895	414	7	414		621	47
48	Flooring	2000	5,028	718	7	718		957	48
49	Wallpaper	2001	15,605	2,229	7	2,229		2,415	49
50	Wallcovering	2002	648	23	7	23		23	50
51	Repave Parking Lot	2002	11,830	563	7	563		563	51
52									52
53	Leasehold Improvements - Management Company:								53
54	Office Construction/Improvements	1995	491		5			491	54
55	Office Design	1995	45		5			45	55
56	Office Shelving	1996	105		4			105	56
57	Office Expansion	1996	463		4			463	57
58	Office Expansion	1997	1,240		3			1,240	58
59	Office Expansion	1998	699		3	52	52	699	59
60	Office Addition	1999	345		3	115	115	345	60
61	Door Locks	1999	172		3	57	57	148	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,480,749	$ 16,589		$ 101,757	$ 85,168	$ 1,261,442	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 267,360	$	$ 28,094	$ 28,094	5-7 Yrs	$ 163,099	71
72	Current Year Purchases	26,279	235	2,223	1,988	5-7 Yrs	2,223	72
73	Fully Depreciated Assets	408,008					407,165	73
74								74
75	TOTALS	$ 701,647	$ 235	$ 30,317	$ 30,082		$ 572,487	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 31,511	$	$ 7,727	$ 7,727	4 Yrs	$ 21,147	76
77										77
78										78
79										79
80	TOTALS			$ 31,511	$	$ 7,727	$ 7,727		$ 21,147	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,424,237	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,824	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,801	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 122,977	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,855,076	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	28,829	$ 184,200	$	28,829	$ 184,200	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,119	17,679		1,119	17,679	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		30,977	279,586		30,977	279,586	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts			201,295			201,295	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Lab, X-Ray, Enterals Other (specify): & I.V. Therapy	39-8				36,655			36,655	13
14	TOTAL			$	60,925	$ 719,415	$	60,925	$ 719,415	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 445,941	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,000)	1,223,357		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,669,298	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	132,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(63,793)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,073	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,738,371	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 434,699	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	698,623		29
30	Accrued Salaries Payable	218,609		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,665		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,715		32
33	Accrued Interest Payable	32,912		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	204,260		36
37	Accrued Rent	(128,392)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,631,091	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,631,091	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 107,280	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,738,371	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 96,803	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 96,803	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	146,477	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(136,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,477	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 107,280	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,344,428	1
2	Discounts and Allowances for all Levels	(2,625,464)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,718,964	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,487,864	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,487,864	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,112	13
14	Non-Patient Meals	8,726	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,838	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,698	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,698	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellanous	955	28
28a	Lab Discounts	2,082	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,037	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,237,401	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	787,188	31
32	Health Care	2,885,607	32
33	General Administration	1,410,591	33
	B. Capital Expense		
34	Ownership	1,595,348	34
	C. Ancillary Expense		
35	Special Cost Centers	242,290	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,986,724	40
41	**Income before Income Taxes (line 30 minus line 40)****	250,677	41
42	**Income Taxes**	(104,200)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 146,477	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,124	2,258	$ 54,100	$ 23.96	1
2	Assistant Director of Nursing	2,048	2,177	47,894	22.00	2
3	Registered Nurses	17,117	18,190	372,081	20.46	3
4	Licensed Practical Nurses	26,849	28,532	488,769	17.13	4
5	Nurse Aides & Orderlies	74,737	79,421	777,348	9.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,005	4,256	56,858	13.36	8
9	Activity Director					9
10	Activity Assistants	5,049	5,365	41,321	7.70	10
11	Social Service Workers	3,070	3,262	32,883	10.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,796	22,099	178,315	8.07	15
16	Dishwashers					16
17	Maintenance Workers	2,039	2,167	21,407	9.88	17
18	Housekeepers	16,065	17,072	119,544	7.00	18
19	Laundry	5,424	5,764	38,889	6.75	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,943	13,754	142,172	10.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,622	4,911	66,592	13.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,888	209,228	$ 2,438,173 *	$ 11.65	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	285	$ 6,859	1-3	35
36	Medical Director	Contract	25,363	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	1,960	11-3	44
45	Social Service Consultant	70	1,960	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	$ 36,142		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,182	31,574	10-3	51
52	Nurse Aides	1,077	19,381	10-3	52
53	TOTAL (lines 50 - 52)	2,259	$ 50,955		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Hunter	Administrator	0.00	$ 47,902
Blair	Administrator	0.00	9,971
Total Direct Administrator Cost from HSM Mgmt - Line 17, col. 7			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 57,873

B. Administrative - Other

Description	Amount
Management Fee	$ 870,877
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 870,877

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 8,227
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 8,227

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,039
Unemployment Compensation Insurance	20,624
FICA Taxes	183,854
Employee Health Insurance	4,414
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	885
Employee Relations	1,164
Management Company Allocations	32,191
TOTAL (agree to Schedule V, line 22, col.8)	$ 295,171

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,099
Health Care Worker Background Check	
(Indicate # of checks performed 85)	1,190
Promotional Advertising	4,414
Misc. Dues/Subscriptions	7,631
Management Company Allocations	612
Less: Public Relations Expense	(218)
Non-allowable advertising	(450)
Yellow page advertising	(3,746)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,532

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	935
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 935

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **59,202** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,726**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **C.J. Schlosser & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not finished**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF MOLINE
IDPH ID #0036152
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2002

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT **	$7,137
	7,137

** ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTED WHICH WERE LESS THAN $250.00 EACH.

ROSEWOOD CARE CENTER INC. OF MOLINE
RECLASSIFICATIONS
06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(16,824)
DEPRECIATION	30	16,824
TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL		

ROSEWOOD CARE CENTER OF MOLINE
IDPH ID #0036152
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2002

RELATED NURSING HOME:	CITY:
ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
MOLINE REAL ESTATE, INC.	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY